

**Adolescent Reproductive Health  
in  
Indonesia**

**Consultancy report by**

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# **I. BACKGROUND**

## **1.1. Introduction**

Young people aged 10-24 years constitute a large proportion of the Indonesian population. The Indonesian Population censuses of 1980 and 2000 showed that this group made up 31 percent of the total population of Indonesia in 1980 and 30 percent in 2000. Like their counterpart in other Asian countries, Indonesian young people are also experiencing extremely rapid social, cultural and demographic changes. Over two decades, the proportion of young people who are in school increased from 19 percent of the population aged 15-24 in 1980 to 28 per cent in 2000. In line with the educational improvement, the singulate mean age at first marriage of women aged 15-49 increased from 20 in 1980 to 23 in 2000 (BPS, 2001a). As a consequence, the proportion of single young people increased from 39 percent of young people aged 15-24 in 1980 to 50 percent in 2000. The proportion of young people in the labor force also slightly increased from 42 of the population aged 15-24 in 1980 to 45 percent in 2000 (BPS 1981; 2001b). These important changes, together with urbanization and the explosion of information across frontiers, have increased the exposure of Indonesian young people to the risks related to reproductive health.

Despite the growing awareness of the importance of adolescent reproductive health (ARH) in Indonesia, there is no clear Government policy. The suggestion to give reproductive health information and services to single young people is still controversial; the Government is trying to reach consensus in this highly contentious area by working intensively with international agencies and Non-Government Organizations (NGOs). In addition to the sensitivity of the issues, the availability of data that can be used to design efficient and effective programs for adolescents, especially those unmarried, is not sufficient.

## **1.2 Adolescents: Who Are They?**

Adolescence is variously defined as a period of transition from childhood to adulthood. It involves a rapid change in many aspects including the biological, psychological and socio-cultural. The World Health Organization (WHO) has defined adolescence as progression from the onset of secondary sex characteristics to sexual and reproductive maturity; development of adult mental processes and adult identity and transition from socio-economic dependence to relative independence (WHO, 1975 cited in Population Reports, 1995:3). Biologically, an individual's entry into puberty is the most widely accepted indicator of beginning adolescence. Since there is no meaningful biological marker to denote the end of adolescence, social factors are usually used to define entry into adulthood. These include marriage, entry into the labor force or financial independence. Regardless her/his age most Indonesian societies regard an individual as an adult once he/she marries.

The age range of adolescence varies according to cultures and the purpose for which they are used. In Indonesia many studies on adolescent reproductive health define adolescents as young people aged 15-24 years (YKB, 1993; Utomo, 1997; LD-FEUI, 1999; Situmorang, 2001). This is because many parents believed that children who are still in primary school are too young to be interviewed about issues related to sexuality. In their programs, the Ministry of Health defines adolescents as those aged 10-19 years (Irdjati SA, 1997:24), while BKKBN's programs define adolescents as those aged 10-24 years. In daily life, adolescents (*remaja*) are commonly referred

to those who are single and aged around 13-16 years, or those who are in junior or senior high school. In this report, adolescents and young people refer to those aged 10-24 years, but due to available research literature, adolescents and young people mostly refer to those aged 15-24 years.

### **1.3. Cultural and Traditional Views regarding Puberty and Sexuality**

Traditionally, in most Indonesian societies, puberty is often regarded as an individual's maturity and readiness for marriage and sexual activity. Therefore in rural areas marriage soon after menarche is common (Hanum, 1997). Although they are considered sexually mature, sex is rarely discussed with unmarried teenagers. In fact, sex is rarely discussed openly in the family or seriously in society in general (Koentjaraningrat, 1985; Husny, 1986:83; Singarimbun, 1975:48). Even among adults, there is a basic conservatism about discussing sex. Information regarding sexual matters is usually given by the mother to her daughter when the girl reaches menarche, but after that there is no discussion in the family regarding sex. For boys, knowledge about sex is mostly gained from informal sources such as peers, pornography and the press. There is almost no communication between father and son or mother and son on these matters.

Given these facts, it is a little surprise to find that both parents and young people today are uncomfortable talking about sexual issues. Apart from the sensitivity of the issues, studies in Jakarta found that most parents felt inadequate to talk to their children about issues related to reproductive health (Iskandar, 1995; Utomo, 1997). Parents do not know how to deal with their children's sexuality any better than young people know how to deal with it themselves.

In the past, soon after puberty the division between the sexes was maintained more firmly: boys and girls did not play together. Girls were expected to remain chaste until marriage; an intact hymen was evidence of this. Virginity was regarded as a symbol of morality, therefore a woman's virginity was very important in a marriage. Failure to prove virginity (usually by the traces of blood on the marital bed) could cause the breakup of the marriage (Alwi, 1962; Yusuf, 1966).

Boys in contrast were commonly given more sexual freedom than girls and were not burdened by any physical evidence of sexual experience. In many societies, a man is expected to know about sexual intercourse before marriage. Premarital sex among young men is encouraged and considered necessary for success in the male sex role (Kiem, 1993:150; Magnis-Suseno, 1997:175). Usually young men learn about sexual intercourse from prostitutes.

## **II. CURRENT ADOLESCENT REPRODUCTIVE HEALTH STATUS**

### **2.1. Puberty**

Studies in developed countries have noted that age at menarche among girls has declined over time (Wysack and Fish, 1982 cited in Bongaarts and Cohen, 1998). Considering the substantial improvement in nutritional status, a similar trend can be expected in developing countries for both males and females. In Indonesia there has been no study on the trend of age at menarche or wet dreams among Indonesian adolescents. Nevertheless, it is predicted the trend is no different from that in other developing countries.

Studies in developed countries have suggested that the rapid biological changes during puberty may cause embarrassment and even stress for many girls and boys (Golub, 1983; Martin, 1996). These negative attitudes are mostly due to inadequate knowledge. Similar experiences were also found among young people in Indonesia. Compared to their parents, adolescents today receive better information and less restriction regarding puberty and sexuality; but misinformation is still evident. Many adolescents are unsure of what is happening to them when they menstruate or have a wet dream (LD-FEUI, 1999; Situmorang, 2001). The reasons for menstrual blood and wet dreams are puzzling to them. Menstrual blood is considered as dirty blood, and something dirty must be hidden. Boys feel guilty the first time they experience wet dreams, because they believe that having a sex dream is a sin. These negative attitudes may discourage Indonesian adolescents from learning more about health aspects of these natural bodily functions.

## **2.2. Marriage**

### **2.2.1. Age at Marriage**

The 1997 Indonesia Demography and Health Survey (IDHS) indicates that there is a significant increase in age at first marriage among women across cohorts. One in five women age 45- 49 was married by age 15, compared with less than six and four per cent of women age 20-24 and 15-19, respectively (BPS, 1998:115). There are large differences in age at first marriage between urban and rural women and between educated and less educated women. For all age cohorts, urban women marry at least two years later than rural women. The median age at first marriage for urban women age 25-29 is 22.7 years compared to 18.9 years for rural women in the same age group. While for women with some secondary education the median age at first marriage is 22 years, for women with less than primary education it is 17 years or younger. The gap is larger among younger women than older women.

As the age at marriage increased, the proportion of single males and females aged 15-24 has increased. Nevertheless in rural areas, as marriage continues to occur at very young ages, the proportion of single adolescents is lower. In 2000, 95.6 per cent of teenage girls aged 15-19 in urban were single compared to 84.6 per cent of those in rural areas (Table 1).

In contemporary Indonesian society, especially in urban areas where education facilities are better, most parents encourage their children to finish high school or even university. Educated people tend to marry later than less educated. In addition, the Government encourages young people to delay marriage until at least 20 for females and 25 for males. This campaign seems to be successful, especially in urban areas. Micro studies suggest that the ideal age at first marriage among young people in urban areas has increased significantly (YKB, 1993; LD-FEUI, 1999).

Studies in rural area, however, indicate that a significant number of girls, especially those who come from low-income families, marry at a very young age. A study among Javanese migrants in rural Bengkulu found that it is common for parents to arrange marriage for their daughters soon after menarche (Hanum, 1997). Similar findings results are reported in a study of several rural areas in West, Central and East Java (Indraswari, 1999). Both studies suggest that this phenomenon occurs mostly due to economic reasons rather than cultural.

### 2.2.2. Childbearing

Teenage women who bear children—wanted or unwanted—may face serious health risks for themselves and their children. Even under optimal condition, young mother, especially those under 17, are more likely than women in their 20s to suffer pregnancy—related complications or to die in childbirth (Population Report, 1995:14). The 1997 IDHS indicated that 12 per cent of married women aged 15-19 years are already mothers or are currently pregnant. Rural adolescents and those with less education tend to start childbearing earlier than those in urban areas. The proportion of adolescents who are pregnant or have delivered a baby is three times higher than adolescents in urban areas.

### 2.3. Premarital Sex

Due to the sensitivity of the issue, in large-scale surveys in Indonesia information regarding sexual activity has only been asked to those who are married. As a consequence, there are no national data on sexual activity of the unmarried. However, micro studies suggest that sexual intercourse prior to marriage among Indonesian young people is common (Sarwono, 1981; YKB, 1993; Singarimbun, 1996; Utomo, 1997; LD-UI, 1999; Situmorang, 2001). Today young people are increasingly tolerant of premarital sex. Although for most of them a woman's virginity is still a great concern, it is no longer seen as a very important matter in choosing a future wife. The demise of the parent-arranged marriage, and the opportunity for a young man to know his future wife before committing to marriage, mean that a potential wife's personality is more important than her virginity (Utomo, 1997; Situmorang, 2001). A study among unmarried men aged 17-24 years in Yogyakarta and Bali reported that 48 per cent out of 181 respondents in urban Bali and 50 percent of 185 respondents in urban Yogyakarta disagreed that a woman has to preserve her virginity until married (Singarimbun, 1996:118). A study among unmarried young people aged 15-24 years in Medan revealed that only 32 per cent of 875 respondents said that virginity is the most important factor in choosing a future spouse (Situmorang, 2001:95).

With this attitude, many young people are involved in premarital sexual activity. An analysis of the 1991 IDHS indicated that for one in five married women aged 20-24 years at the time of the survey, the first child was conceived prior to marriage (Ono-Osaki, 1992 cited in United Nation, 1993:150). A study among young people aged 15-24 from various socio-economic backgrounds in 12 cities in Indonesia in 1993, revealed that between 10 to 31 percent of youth reported having engaged in premarital sex (YKB, 1993). A study in Medan found that 18 percent (9 percent females and 27 percent males) of single young people aged 15-24 reported having had sex (Situmorang, 2001). Given that premarital sex is not socially accepted, the real proportion is likely to be much higher.

As would be expected, compared to females, males are more likely to approve of premarital sex and more likely to report having had sex. Many young men believe that a man needs sexual experiences before marriage. To obtain such "experience" they usually go to prostitutes. In addition, some boys prefer to have sex with a "casual friend" or prostitute than with their girl friends. The reasons for this is that to have sex with a casual friend or prostitute is considered more fun and no responsibility, while with a girl friend it demands more responsibility (Situmorang, 2001:106).

Non students are more likely to engage in premarital sexual activities than students (YKB, 1993; Situmorang, 2001). Studies in Medan and Kalimantan revealed that many young men who are sexually active visit prostitutes regularly (Hidayana *et al.*, 1997; Saifuddin *et al.*, 1999;

Situmorang, 2001:144). Most of them do not feel a need to use condoms even though they are aware of the possibility of getting STDs; they believe condoms hamper their sexual activities. In-depth interviews and focus group discussions with young men in Medan showed that many of them, especially those who work on the streets, believe that STD's can be prevented by maintaining physical stamina, only having sex with "a clean and healthy" person and taking some 'medicine' before sex (Situmorang, 2001:136).

In addition, many newspapers have reported on the sexual life of young girls who might have sex just for "fun" (*Media Indonesia, Suara Pembaruan, Kompas, Republika*). Based on its reporters' investigations in several cities and small town in Indonesia (such as Jakarta, Medan, Bandung, Semarang, Surabaya, Tasikmalaya and Tegal), *Media Indonesia* published special reports regarding teenagers who pick up men around shopping complexes or other meeting places to engage in sex, sometimes for a pre-arranged fee but often just for the experience or for whatever the man might choose to give (*Media Indonesia*, 2-26 August 1999). They are often still in school and come from relatively better off families. It undoubtedly has much to do with growing consumerism during the era of rapid economic growth that ended abruptly with the economic crisis in late 1997, but might also reflect rebellion against traditional mores, and against the perceived hypocrisy in the attitudes and behavior of many of their middle-class parents (Jones, 2000). Although the percentage of young girls engaging in this activity may be very small and would not represent the image of Indonesian young people, these reports suggest that teenage prostitution is not only a big-city phenomenon but may also be found in small towns such as Tasikmalaya and Tegal. Each place however has a local term to refer to the girls involved in this activity. In Jakarta they are commonly called *perek* (experimental women), in Medan and Bandung they are called *bondon*, in Surabaya *cilik'an* and in Tasikmalaya, *anyanyah*.

#### **2.4. Contraception**

Young people, especially those unmarried, seldom use contraception. Sexually active single young people who have sex with a steady partner often claim that intercourse is not the result of premeditated or conscious decisions but just "happens", so they are unlikely to be prepared with contraception (Khisbiyah *et al.*, 1997). In addition, many young people have limited knowledge of contraception (LD-FEUI, 1999). Ability to name one or more contraceptive methods does not necessarily mean knowledge about use or source of supply. Many young men believe that the use of condom violates their beliefs, causes "weakness" or hampers sexual pleasure. Considering that the Government policy restricts single people's access to family planning information and services, these misconceptions can be understood.

#### **2.5. Unwanted Pregnancy and Abortion**

In Indonesia, as abortion is restricted and childbearing out of wedlock is unacceptable, many premarital pregnancies result in marriage. However, when marriage is not an option, many girls turn to abortion. Since abortion is illegal, it is often performed by unskilled providers in unsafe conditions (Adrina *et al.*, 1998:126; Indraswari, 1999; 131-164). It is estimated that up to half of all pregnancy-related deaths in Indonesia result from the complications of unsafe abortion (Muluk, 1994; cited in Mohamad, 1998:84). A recent study carried out by the Centre for Health Research at the University of Indonesia in 2000, estimated around 2 million abortion cases per year in Indonesia and roughly 30 percent of them were for adolescents (Utomo, *et al.*, 2001)

A qualitative study in Yogyakarta in 1997 among 44 women who had a premarital pregnancy at age 15-24 and had come to IPPF Yogyakarta for consultation, found that 26 respondents reported continuing with the pregnancy and 18 respondents reported terminating the pregnancy (Khisbiyah *et al.*, 1997:43). Of those who continued the pregnancy, 21 respondents married during their pregnancy and only five respondents remained single. Facing the fact of their pregnancy, most girls who decided to continue their pregnancy had attempted abortion (usually by drinking traditional medicine/*jamu*) but failed. PKBI reports indicate that for 1998 and 1999, in Indonesia, there were two million abortions each year, and 750,000 (38 percent) of them were requested by single young women (*Media Indonesia*, 22 October 2000).

## **2.6. Sexually Transmitted Diseases (STD) including HIV/AIDS**

Until recently, there were few official data regarding STDs in Indonesia, especially among adolescents. Most research and programs on STDs are specifically focused on prostitutes and those who visit family planning or maternal health clinics (Daili *et al.*, 1994:3; Hull *et al.*, 1996:230-231, Koeswinarno, 1996, Wirawan *et al.*, 1998). Nevertheless, national data about HIV/AIDS cases suggest that in Indonesia young people aged 20-29 years old are the largest group reported to be HIV positive (DepKes, 2002).

Micro studies and sporadic reports in local medical journals indicate that many adolescents are infected with STDs (Wardhana *et al.*, 1998; Situmorang, 2001). Adolescents have limited knowledge of these contagious diseases (Pangkahila *et al.*, 1998). Although they are aware of the possibility of getting STDs from having sex with prostitutes, some young men, especially those who work on the street, do not feel a need to use a condom. They believe that STDs and AIDS can be prevented by maintaining their physical stamina (eating nutritious food) or taking antibiotics before having sex with a prostitute. When they have contracted an STD, they prefer to buy medicine in drugstores without consulting a doctor. Some do not feel the need to go to a medical doctor because they believe they can cure the disease themselves. Others said they felt uncomfortable to go to a doctor and it cost a lot of money (Situmorang, 2001:147).

## **III. ADOLESCENT REPRODUCTIVE HEALTH ISSUES**

### **3.1. Lack of Knowledge regarding Reproductive and Sexual Health**

As indicated by many micro studies, most Indonesian adolescents have little knowledge of reproductive and sexual health. Lack of knowledge regarding human reproduction has caused some young people to engage in risky sexual behavior. Many believe that a woman cannot become pregnant from a single act of sexual intercourse; therefore to avoid causing a pregnancy, some young men prefer to have sex in a casual relationship or have sex only once in a month with the same girl (Situmorang, 2001). Misunderstandings are also evident among young people on issues related to puberty, fertile period and risks related with sexual behavior such as abortion, STDs and HIV/AIDS.

### **3.2. Premarital Sex**

Indonesian young people are experiencing extremely rapid and bewildering change in values, attitudes and behavior regarding sexuality. They are becoming more liberal in expressing their

sexual feelings, especially those in urban areas. Traditional expectations that young people remain virgins until marriage are incompatible with city life. Access to a variety of entertainment facilities, including night-clubs, discotheques and pornographic materials through movies, videos, magazines, books and the internet, may encourage young people to experiment more with their natural curiosity. Many of them engage in risky sexual behavior: they practice unprotected sex with multiple partners or seek out partners who are likely to carry high risks, such as prostitutes. These place them at high risk of unwanted pregnancy, abortion and STDs, including HIV.

### **3.3. Risks Related to Unsafe Sexual Intercourse**

#### **3.3.1. Unwanted Pregnancy**

As premarital sex increases, the number of young women who become pregnant prior to marriage also increases. In Indonesia, where premarital sex is condemned by society, a single girl who becomes pregnant out of wedlock is generally presented with two choices: marry to legitimize the birth or have an abortion. The adverse societal perceptions of premarital pregnancy and ex-nuptial birth have meant that very few women, especially teenagers, choose to become single mothers. Those who choose to marry face health risks as well as socio-economic problems: teenage pregnancy, regardless of marital status, can be dangerous for both mother and infant. In addition, a young girl is likely to give up her formal education and career and personal growth for her pregnancy. School regulations in Indonesia usually do not allow a pregnant girl to continue her study. On the other hand those who choose to terminate their pregnancies also face serious health risks. Since abortion is illegal, it is often performed by unskilled providers in unsafe conditions.

#### **3.3.2. STDs and HIV/AIDS**

As many young men engage in sexual intercourse activities without protection with multiple partners, including prostitutes, they are likely to experience STDs and HIV/AIDS. Barrier contraception such as condom use that can protect young people from these contagious diseases is not popular among young people. In addition there is a negative reaction from Moslem religious leaders regarding the idea of promoting condoms as a tool to prevent STDs and HIV/AIDS.

### **3.4. Limited Access toward ARH Information and Services**

Young people, especially those who are unmarried, do not receive sufficient information on reproductive health matters. Information regarding puberty and sexual health, mostly gained from friends, mass media, and religious teachers, is likely to be incomplete, uninformative or obscured by religious and moral messages. As most parents still hold conservative norms, they feel uncomfortable about discussing sexual issues with their teenage children. Sex education is rarely found in school curricula. Talking about sex in public is still taboo, and at the state level there is a strong belief that sex should be treated as a private matter and not a public concern. Therefore, sexuality remains marginal in the health and education agendas.

The suggestion to give reproductive health information and services to single young people is still controversial. Although previous studies indicate the opposite (Utomo, 1997), many people, especially religious leaders believe that providing such information and services to adolescents will encourage them to become promiscuous. The Government approach to these highly controversial issues tends to be based on morality, rather than the "health approach". ARH

programs are mostly limited to providing basic information on sexuality and reproductive health but not providing services. The Indonesian Family Welfare Law, UU No. 10/1992 restricts the access of single young people to family planning information and services. In addition, the information provided in the IEC programs is limited to the promotion of family, moral and religious values rather than information on sexual health such as how to avoid unsafe sex. Consequently, the reproductive health needs of single but sexually active young people remain unfulfilled.

## **IV. POLICIES AND PROGRAMS**

### **4.1. ARH-Related Policies**

In accordance with the consensus in the 1994 International Conference on Population and Development (ICPD) and the 1995 Beijing conference, the Indonesian Government is increasingly aware of the need for comprehensive sexual and reproductive health programs for young people. Recently, the Indonesian government through BKKBN, the Ministry of Health, Ministry of National Education, Ministry of Religion and Ministry of Social Affairs and other research institutes, has started programs and research related to adolescents' reproductive health (YKB, 1993; Irdjati, 1997; LD-UI, 1999). These activities are conducted in collaboration with international donor agencies such as UNFPA, Ford Foundation, WHO, Population Council, IPPF, USAID and AusAID. However until recently most ARH programs were pilot projects that had yet to be evaluated.

Five years after the introduction of the ICPD – Programme of Action the political support for ARH programs in Indonesia improved significantly. In 1999, the State Minister of Women's Empowerment and Head of BKKBN established a special division to deal with adolescents' and reproductive rights protection. Then in the next year, in 2000, both the Government and the Parliament agreed to include ARH programs in the 2000-2004 National Development Programs (*Program Pembangunan Nasional/Propenas*). This means that ARH programs have become one of the national priorities for development and all programs and activities related to this issue will be supported by the Government.

However there are some laws and regulations that still need to be reviewed in order to make a better environment for ARH policy and programs in Indonesia. Among them are the Family Welfare Law (UU No. 10/1992), the Marriage Law (UU. No. 1/1974) and the Health Law (UU No. 23/1992).

#### **4.1.1. The Family Welfare Law UU No. 10/1992**

According to the Indonesian "Family Welfare" Law, family planning programs are only available to married couples or families. Thus, giving young single people family planning services is considered illegal. The existing family planning programs, consequently, have concentrated upon married women of reproductive age (between 15-49). Considering the rapid increase of risks related to sexual behavior among Indonesian single young people, many youth experts strongly suggest to review this law.

#### 4.1.2. Marriage Law UU. No. 1/1974.

The legal minimum age of marriage for females is 16 years and for males is 19 years. However, before an individual has reached 21 years, he/she needs to obtain permission of his/her parents to marry. These are mentioned in article no 6 and 7 of the Marriage law UU. No. 1 of 1974:

*Perkawinan harus dengan persetujuan kedua mempelai. Bagi yang belum mencapai 21 tahun harus mendapat izin kedua orang tua... Perkawinan hanya diizinkan jika pihak pria sudah mencapai umur 19 tahun dan pihak wanita 16 tahun.*

(A marriage has to be based on agreement of both the bride and the groom. For those who have not reached 21 years old they have to obtain permission from both parents...A marriage is allowed if a man has reached the age of 19 years and a woman is 16 years).

Biologically a teenage woman's reproductive organs have yet to grow further, therefore for health reasons it is better to increase the legal minimum age of marriage. In rural areas, this law is often used as a justification to continue the traditional practice of early marriage (Hanum, 1997).

#### 4.1.3. Health Law: No. 23/1992

According to the Indonesian Criminal Code enacted in 1918 and Indonesian Health Law No 23/1992, abortion is a crime against morals and life. Nevertheless the meaning of terms used in the Health Law have created uncertainties. Health Law No. 23 of 1992 article 15, section 2 paragraph (1) states that:

In case of emergency, and with the purpose of saving the life of a pregnant women or her fetus, it is permissible to carry out certain medical procedures.

Then this paragraph is clarified with the following:

Medical procedures in the form of "abortion" (*pengguguran kandungan*), for any reason, are forbidden as they violate legal norms, religious norms, ethical norms, and norms of propriety. Nevertheless, in case of emergency and with the purpose of saving the life of a pregnant woman and/or the fetus in her womb, it is permissible to carry out certain medical procedures.

As noted by Hull *et al.* (1993), the explanation of the paragraph contradicts the substance of the paragraph itself. Furthermore they argue that the terms used in the explanation have created two uncertainties; linguistic confusion over the term "certain medical procedures" and the unclear meaning of "violate legal norms, ethical norms, religious norms and norms of propriety" (Hull *et al.*, 1993:245). In addition issues regarding the exact time a fetus is considered a human being is still debatable (Mohamad, 1998). In Indonesian there are many opinions regarding this issue; most opinions are based on religious belief.

Despite this law, it is known that abortion is widely practiced by both medical and non-medical personnel (Utomo *et al.*, 1998; Hull *et al.*, 1993). The chairman of the Indonesian Doctor's Association, Azrul Anwar, has stated that doctors were aware their colleagues conducted abortions but there was an unspoken agreement among them not to report such activities, unless their actions had adversely affected a patient (*Jakarta Post*, 13 November 1998:3). Traditionally, abortions have been practiced among many ethnic groups in Indonesia (Utomo *et al.*, 1982;

Singarimbun, 1996). Among Javanese, traditional massage and *jamu* have been used for a long time to “regulate” delayed menstruation (Rahardjo, 1990).

Given the increased number of illegal abortions, many experts, especially medical doctors, have demanded that the government solve the confusion over the Health Law No. 23/1992 and have suggested it should set up an institution to perform legal abortion.

## **4.2. Current Government Programs**

Several government institutes are involved in developing or promoting ARH programs. They are BKKBN, Ministry of Health (MoH), Ministry of National Education (MoNE), Ministry of Religious Affair (MoRA), Ministry of Social Welfare (MoSW) and local governments. However, most of the programs regarding sexual and reproductive health are implemented by BKKBN and MoH. BKKBN is responsible for co-ordinating reproductive health programs for the nation. MoH through its hospitals, clinics and subclinics is responsible for reproductive health services; MoNE with its large network of schools is important for reaching young people to provide reproductive health information and educational materials. MoRA and MoSW both have networks reaching the community in general, especially out-of-school young people (Wilopo *et al.*, 1999; Ford and Siregar, 1998).

The government ARH programs are mostly limited to providing general information on reproductive health. They include integrated services with information, educational and counseling (IEC) materials that address young people’s sexual reproductive health problems such as unwanted pregnancy, unsafe abortion, STDs and HIV. However, the content of the IEC programs is limited to the promotion of family, moral and religious values (Djaelani, 1996; Tumkaya, 2000). This approach undoubtedly involves no significant information or services related to family planning and sexual health for unmarried youth. The provision of sexual and reproductive health information and services to young people is limited to NGOs (Gunawan, 1995:7; Wilopo *et al.*, 1999:38); it is obviously still inadequate in quantity or quality owing to financial constraints as well as to human resources.

### **4.2.1. BKKBN**

To provide information regarding adolescents’ sexual and reproductive health for both young people and parents, BKKBN in collaboration with UNFPA has introduced various training modules both for parents and adolescents. These innovations involve family, parents and relatives who are responsible for children during adolescent years. Nevertheless, since the modules are not incorporated in the school curricula and are distributed to a limited number of people and organizations, they have not reached most adolescents and parents.

### **4.2.2. Ministry of Health**

The Ministry of Health has initiated a counseling program for adolescents in junior and high schools by providing information about adolescents’ reproductive health to teachers and those responsible for teenagers (Irdjiati, 1997:20). The Ministry of Health through its *puskesmas* in several areas has established a program to serve adolescent reproductive health needs. In 1999, the Ministry of Health in collaboration with WHO also published an ARH pocket book (*buku saku*) for adolescents aged 14-19 years. Nevertheless, with BKKBN’s modules, this book is distributed to a limited number of people and has not reached most adolescents.

#### 4.2.3. Ministry of National Education

The Ministry of National Education, in collaboration with the World Bank, has introduced a pilot project on “adolescent reproductive health education” in 10 cities in the Central and East Java; this project focuses on training and information for junior and high school teachers about the importance of adolescent reproductive health. However until recently, sex education is rarely found in the school curricula.

### 4.3. Non Government Organization Programs

Since providing sexual and reproductive health information and services for unmarried young people is restricted under Government programs, NGOs are expected to be active in filling the gaps. In many big cities established NGOs have collaborated with international funding agencies such as Ford Foundation, IPPF, UNFPA, UNDP, Population Council and World Bank; these agencies have also helped establish special-purpose NGOs to provide services to young people. Compared to the Government programs, those of NGOs seem to be more realistic in approaching unmarried young people’s needs. Several established NGOs have provided information and services directly to young people both in school and out of school. However, given the limited budget and human resources of many NGOs in Indonesia, it is impossible to expect the programs to reach the majority of Indonesian young people.

One of the most important NGOs providing such information and services in Indonesia is the Indonesian Planned Parenthood Association (PKBI), which has 26 branch offices in many cities across the archipelago. Since 1991, in collaboration with the IPPF, PKBI has promoted youth centers to provide information and counseling for young people on issues related to sexual and reproductive health. As the aim of these centers is to provide peer education, those working in the centre are young people. Young people who may need medical attention are referred to the PKBI clinics. Despite the government policy to restrict abortions, almost all PKBI clinics perform abortions for a broad range of reasons. The procedure is commonly called menstrual regulation (MR), and takes place before 12 weeks of gestation. For unmarried young people to proceed with MR services, the parent’s approval is needed, while for a wife, the husband’s written approval needs to be provided.

## V. RECOMMENDATIONS FOR ACTION TO IMPROVE ARH

A clear program perspective about the rights of adolescents to a full range of sexuality and reproductive health information and services needs to be communicated to the public to create an enabling policy environment for the provision of ARH services.

The perspective of parents and the community needs to be more understanding and accepting of programs that respond to the unmet needs of adolescents’ sexual and reproductive health.

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## Appendix 1: Tables

Table 1 Proportion of Indonesian single young people still single by sex and urban-rural, 1980 and 2000

	Males		Females		Males & Females	
	1980	2000	1980	2000	1980	2000
Urban						
10-15 years	99.5	99.6	99.0	99.6	99.5	99.2
15-19 years	97.9	98.2	82.2	95.6	89.8	94.8
20-24 years	73.7	82.9	37.3	77.6	54.7	68.0
Rural						
10-15 years	99.2	99.0	99.0	99.4	99.1	99.2
15-19 years	95.8	97.2	65.4	84.6	80.4	89.7
20-24 years	53.6	70.2	17.1	44.1	33.4	48.9

Sources: CBS, 1981; 2001b

Table 2. Proportion of Indonesian young people in school by sex and urban-rural, 1980 and 2000

	Males		Females		Males & Females	
	1980	2000	1980	2000	1980	2000
Urban						
10-15 years	90.3	n.a	85.8	n.a	88.1	n.a
15-19 years	60.4	55.1	43.4	51.8	51.7	53.4
20-24 years	18.6	16.9	8.7	13.5	13.4	15.0
Rural						
10-15 years	73.1	n.a	70.6	n.a	71.9	n.a
15-19 years	28.5	37.9	17.1	36.4	22.7	37.2
20-24 years	4.1	4.8	1.2	3.1	2.5	4.0

Note: n.a = not available.

Sources: CBS, 1981; 2001b

Table 3. Proportion of Indonesian young people in labor force by sex and urban-rural, 1980 and 2000

	<b>Males</b>		<b>Females</b>		<b>Males &amp; Females</b>	
	<b>1980</b>	<b>2000</b>	<b>1980</b>	<b>2000</b>	<b>1980</b>	<b>2000</b>
Urban						
10-15 years	3.1	n.a	4.0	n.a	3.5	n.a
15-19 years	23.4	19.9	20.4	21.0	21.8	20.5
20-24 years	60.3	57.6	25.7	43.0	42.8	50.1
Rural						
10-15 years	15.0	n.a	10.5	n.a	12.8	n.a
15-19 years	53.8	35.7	33.3	33.4	43.5	16.2
20-24 years	83.0	72.7	35.1	58.0	56.6	65.0

Note : na = not available.

Sources: CBS, 1981; 2001b